WISCONSIN MEDICAID
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services. The use of this form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

INSTRUCTIONS: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested oxygen-related equipment or supplies. All oxygen-related services must be prescribed by a physician prior to providing the service. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Providers may attach a photocopy of the physician's prescription to the completed Prior Authorization/Oxygen Attachment (PA/OA), HCF 11066, or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to receipt by Wisconsin Medicaid. Attach the PA/OA to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, HCF 11067, or a copy of the recipient's oxygen use records to the PA/OA for recipients who reside in a nursing home.

Providers may submit PA requests to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Medical Equipment Vendor
Enter the name of the medical equipment vendor (oxygen provider).

Element 2 — Medical Equipment Vendor's Medicaid Provider No.
Enter the eight-digit Medicaid provider number of the medical equipment vendor (oxygen provider). The provider number in this element must correspond with the provider name listed in Element 1.

Element 3 — Telephone Number — Medical Equipment Vendor
Enter the medical equipment vendor's telephone number, including area code.

Element 4 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/CCYY format.

Element 5 — Name — Person Completing Form
Enter the name of the person completing this form if other than the treating physician.

Element 6 —Title — Person Completing Form
Enter the title of the person completing this form if other than the treating physician (e.g., respiratory therapist, home health nurse, billing manager).

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 8 — Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number
Enter the eight-digit Medicaid provider number or the six-character Universal Provider Identification Number (UPIN) of the prescribing physician. The provider number or UPIN in this element must correspond with the provider name listed in Element 7.

Element 9 — Address — Prescribing Physician
Enter the complete address (street, city, state, and zip code) of the prescribing physician.

Element 10 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

SECTION II — RECIPIENT INFORMATION

Element 11 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial.

Element 12 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System to obtain the correct identification number.

Element 13 — Height and Weight — Recipient
Enter the recipient's height in inches and weight in pounds. This field is optional unless height and weight are related to respiratory diagnosis.

Element 14 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/CCYY format (e.g., February 10, 1927, would be 02/10/1927).

Element 15 — Place of Service
Select the appropriate place of service (POS) code. If POS code "31" (Skilled nursing facility) or "32" (nursing facility) are selected, complete Element 16.

Element 16 — Name and Address — Facility (if applicable)
Enter the name and address of the nursing facility in which the recipient resides, if applicable.

SECTION III — CLINICAL INFORMATION

Element 17 — Estimated Length of Need
Enter the estimated time (in months) that the recipient will require oxygen. If the physician expects that the recipient will require the item for the duration of his or her life, then enter "99."

Element 18 — Diagnosis — Codes and Descriptions
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* diagnosis codes and descriptions most relevant to the oxygen-related services requested.

Note: Medical equipment vendors may choose to provide only a written description.

Element 19 — Qualifying Test
Enter the results of the qualifying test taken within 60 days prior to the date of submission or requested start date of the PA request. The criteria for coverage of oxygen-related services include one or both of the following:

- Oxygen saturation level (SAO_2) of 88 percent or lower.
- Arterial blood gas level (PO_2) of 55 mm/Hg or lower.

Test results must have been taken within 60 days prior to the date of submission or the requested start date. Test results are to be available in the recipient's record or case file.

Element 20
Enter the oxygen liter flow rate/number of hours per day ordered by a physician. If not used on a scheduled basis, describe circumstances and frequency of use.

Element 21 — Type of Oxygen Prescribed
Indicate the type of oxygen requested.

Element 22 — Means of Delivery Prescribed
Indicate the means of delivery of the oxygen.

Element 23
Answer questions a-c about portable oxygen and recipient mobility information.

Element 24
If the recipient's arterial blood gas level (PO_2) is 56 mm/Hg or above or the recipient's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

Element 25
Describe the medical condition of the recipient that supports the use of oxygen (e.g., describe why the recipient needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

Element 26 — Date of Prescription
Enter the date of the physician's prescription in MM/DD/CCYY format.

Element 27 — Prescription as Written
Enter the physician's prescription as it is written. If the prescribing physician signs the PA/OA, Wisconsin Medicaid will accept it in lieu of the physician's written prescription and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by Wisconsin Medicaid or the requested start date of the PA request.

Element 28 — SIGNATURE — Prescribing Physician
The original signature of the provider prescribing the oxygen-related services must appear in this element or the physician's prescription must be attached to the PA request.

Element 29 — Date Signed
Enter the month, day, and year the PA/OA was signed in MM/DD/CCYY format.